

<i>SERFF Tracking Number:</i>	<i>UHLC-127756046</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>50098</i>
<i>Company Tracking Number:</i>	<i>IROEXT (01/12)</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>IRO Amendment/</i>		

## Filing at a Glance

Company: Unimerica Insurance Company

Product Name: Stop Loss

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Filing Type: Form

SERFF Tr Num: UHLC-127756046 State: Arkansas

SERFF Status: Closed-Approved-Closed  
State Tr Num: 50098

Co Tr Num: IROEXT (01/12)

State Status: Approved-Closed

Authors: Jayne Jackowski, Lynn Powers

Reviewer(s): Rosalind Minor

Disposition Date: 10/31/2011

Date Submitted: 10/25/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: IRO Amendment

Project Number:

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type:

Filing Status Changed: 10/31/2011

State Status Changed: 10/31/2011

Created By: Jayne Jackowski

Corresponding Filing Tracking Number:

Filing Description:

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Jayne Jackowski

We respectfully submit the proposed Stop Loss forms for your approval. These are new forms and are not intended to replace any forms previously filed with the Department.

These forms will be used with previously approved forms to insure eligible groups that self-insure their health benefit plans against specific and/or aggregate excess losses. The previous policy form number is UMEREL (02/02) and was approved by your office on April 29, 2002. Previously approved forms will also be used for any eligible group allowed under Arkansas state law.

<i>SERFF Tracking Number:</i>	<i>UHLC-127756046</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>IROEXT (01/12)</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>IRO Amendment/</i>		

The endorsement provides an extension of up to 12 months to the time period to pay claims under the Excess Loss Insurance Policy (the paid portion of the Benefit Period). Due to the possible lag in payment of claims if a denial is reversed by an external review, we believe this feature should be available to our Policyholders.

Certain provisions have been [bracketed] to indicate they are variable and other provisions have been {bracketed} to indicate they are variable by omission. You have our assurance that only variable areas will be changed and or omitted.

## Company and Contact

### Filing Contact Information

Jayne Jackowski, Senior Specialty Product Analyst	Jayne_S_Jackowski@uhc.com
3100 AMS Blvd.	800-232-5432 [Phone] 14405 [Ext]
Green Bay, WI 54313	920-661-9861 [FAX]

### Filing Company Information

Unimerica Insurance Company	CoCode: 91529	State of Domicile: Wisconsin
PO Box 150450	Group Code: 707	Company Type: Life and Health
Hartford, CT 0606115-0450	Group Name:	State ID Number:
(860) 702-6017 ext. [Phone]	FEIN Number: 52-1996029	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Unimerica Insurance Company	\$50.00	10/25/2011	53158348
Unimerica Insurance Company	\$100.00	10/26/2011	53220509

SERFF Tracking Number:	UHLC-127756046	State:	Arkansas
Filing Company:	Unimerica Insurance Company	State Tracking Number:	50098
Company Tracking Number:	IROEXT (01/12)		
TOI:	H12 Health - Excess/Stop Loss	Sub-TOI:	H12.004 Self-Funded Health Plan
Product Name:	Stop Loss		
Project Name/Number:	IRO Amendment/		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/31/2011	10/31/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/26/2011	10/26/2011	Jayne Jackowski	10/26/2011	10/26/2011

*SERFF Tracking Number:*      *UHLC-127756046*

*State:*      *Arkansas*

*Filing Company:*      *Unimerica Insurance Company*

*State Tracking Number:*      *50098*

*Company Tracking Number:*      *IROEXT (01/12)*

*TOI:*      *H12 Health - Excess/Stop Loss*

*Sub-TOI:*      *H12.004 Self-Funded Health Plan*

*Product Name:*      *Stop Loss*

*Project Name/Number:*      *IRO Amendment/*

## **Disposition**

Disposition Date: 10/31/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>UHLC-127756046</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Unimerica Insurance Company</i>	<i>State Tracking Number:</i>	<i>50098</i>
<i>Company Tracking Number:</i>	<i>IROEXT (01/12)</i>		
<i>TOI:</i>	<i>H12 Health - Excess/Stop Loss</i>	<i>Sub-TOI:</i>	<i>H12.004 Self-Funded Health Plan</i>
<i>Product Name:</i>	<i>Stop Loss</i>		
<i>Project Name/Number:</i>	<i>IRO Amendment/</i>		

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Explanation of Variables	Approved-Closed	Yes
<b>Form</b>	Extended Liability Endorsement	Approved-Closed	Yes
<b>Form</b>	Policy Schedule	Approved-Closed	Yes
<b>Form</b>	Application for Excess Loss Insurance	Approved-Closed	Yes

SERFF Tracking Number: UHLC-127756046 State: Arkansas  
Filing Company: Unimerica Insurance Company State Tracking Number: 50098  
Company Tracking Number: IROEXT (01/12)  
TOI: H12 Health - Excess/Stop Loss Sub-TOI: H12.004 Self-Funded Health Plan  
Product Name: Stop Loss  
Project Name/Number: IRO Amendment/

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 10/26/2011  
Submitted Date 10/26/2011

Respond By Date

Dear Jayne Jackowski,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Extended Liability Endorsement, IROEXT (01/12) (Form)
- Policy Schedule, UMEREL (01/12) SCHED (Form)
- Application for Excess Loss Insurance, UMERAPP-AR (01/12) (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	UHLC-127756046	State:	Arkansas
Filing Company:	Unimerica Insurance Company	State Tracking Number:	50098
Company Tracking Number:	IROEXT (01/12)		
TOI:	H12 Health - Excess/Stop Loss	Sub-TOI:	H12.004 Self-Funded Health Plan
Product Name:	Stop Loss		
Project Name/Number:	IRO Amendment/		

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/26/2011
Submitted Date	10/26/2011

Dear Rosalind Minor,

### Comments:

### Response 1

Comments: The additional \$100 has been submitted.

### Related Objection 1

Applies To:

- Extended Liability Endorsement, IROEXT (01/12) (Form)
- Policy Schedule, UMEREL (01/12) SCHED (Form)
- Application for Excess Loss Insurance, UMERAPP-AR (01/12) (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

*SERFF Tracking Number:*      *UHLC-127756046*

*State:*      *Arkansas*

*Filing Company:*      *Unimerica Insurance Company*

*State Tracking Number:*      *50098*

*Company Tracking Number:*      *IROEXT (01/12)*

*TOI:*      *H12 Health - Excess/Stop Loss*

*Sub-TOI:*      *H12.004 Self-Funded Health Plan*

*Product Name:*      *Stop Loss*

*Project Name/Number:*      *IRO Amendment/*

Sincerely,

Jayne Jackowski, Lynn Powers



SERFF Tracking Number:	UHLC-127756046	State:	Arkansas
Filing Company:	Unimerica Insurance Company	State Tracking Number:	50098
Company Tracking Number:	IROEXT (01/12)		
TOI:	H12 Health - Excess/Stop Loss	Sub-TOI:	H12.004 Self-Funded Health Plan
Product Name:	Stop Loss		
Project Name/Number:	IRO Amendment/		

## Form Schedule

### Lead Form Number: IROEXT (01/12)

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/31/2011	IROEXT (01/12)	Policy/Cont ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Extended Liability Endorsement	Initial			IROEXT _01.12_.pdf
Approved-Closed 10/31/2011	UMEREL (01/12)	Schedule Pages	Policy Schedule	Initial			UMEREL _01.12_ SCHED.pdf
Approved-Closed 10/31/2011	UMERAPP-AR (01/12)	Application/ Enrollment Form	Application for Excess Loss Insurance	Initial			UMERAPP- AR _01.12_.pdf

**[INDEPENDENT REVIEW ORGANIZATION]**

**EXTENDED LIABILITY ENDORSEMENT**

Policyholder: [ ]

Effective Date: [ ]

In consideration for the premium shown in the Schedule of Excess Loss, the Excess Loss Insurance Policy (the "Policy") will be revised as outlined below.

For each [Specific and Aggregate]<sup>1</sup> Benefit Period, unless and until this Endorsement is terminated, the Policy will be revised as set forth below.

In the event Covered Expenses are Paid for a Covered Person due to [a reversal by an Independent Review Organization]<sup>2</sup> of a previous denial of such Covered Expenses, and such Covered Expenses are then Paid after the last Paid date provided in the Policy Benefit Period (the "Last Paid Date"), the Policy Benefit Period to pay such Covered expenses will be extended for a period not to exceed [twelve (12) months]<sup>3</sup> from the Last Paid Date provided:

- a. [The Policyholder elected this [Independent Review Organization]<sup>4</sup> Extended Liability Endorsement on or before the first day of the Policy Period; and]<sup>5</sup>
- b. Such Covered Expenses are not eligible under any other coverage; and
- [c.] Such Covered Expenses are otherwise payable under the terms of the Policy.

When Covered Expenses are Paid pursuant to the terms and conditions of this Extended Liability Endorsement, such Covered Expenses will relate back to the Policy Benefit Period in which they were Incurred and will be excluded from any other Policy Benefit Period.

[For purposes of this Endorsement, Independent Review Organization means the organization for external review as required under the external review process of the Patient Protection and Affordable Care Act and as covered under the Plan.]<sup>6</sup>

If the Policyholder terminates this Policy for any reason prior to [12 months following the Effective Date shown above]<sup>7</sup>, this Endorsement will be void.

All other provisions of the Excess Loss Insurance Policy remain unaffected by this Endorsement.

[  ]

Secretary

Unimerica Insurance Company

## Unimerica Insurance Company

A Stock Company

[Administrative Offices: 9900 Bren Road East, Minnetonka, MN 55343

Phone: 1-800-454-0233]

### SCHEDULE OF BENEFITS

[This Schedule of Benefits is only applicable to Excess Loss Insurance provided by the Company during the Policy Period shown below.

Policyholder: ABC Company, Inc.  
Policy Number: 12345  
{Original} Effective Date: \_\_\_\_\_  
{Subsequent Policy Period Effective Date: \_\_\_\_\_}  
Administrator: \_\_\_\_\_

Coverage specified herein is applicable only during the Policy Period from 1/01/01/01 to 12/31/01, and is further subject to all terms and conditions of this Policy.

**SPECIFIC EXCESS LOSS INSURANCE** ( X ) Yes ( ) No

Benefit Period: [Covered Expenses Incurred from 10/01/00 through 12/31/01  
and Paid from 01/01/01 through 12/31/01.

[If this Policy has a Subsequent Policy Period, the Benefit Period is changed to:

Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ and Paid from \_\_\_\_\_ through \_\_\_\_\_; or, through any termination within the next Benefit Period, whichever is earlier.]

Covered Expenses Incurred from 10/1/00 through 12/31/2000 will be limited to \$50,000 per Covered Person.]

Specific Deductible per [( X ) Covered Person {( ) family } ] \$ 25,000

Specific Percentage Reimbursable [100 %]

Maximum Specific Benefit per [(X ) Covered Person {( ) family} ] ☐ Unlimited ☐ Other \$ \_\_\_\_\_ ]

Specific Excess Loss Insurance includes:

[( ) Medical ( X ) Stand Alone Prescription Drug Program]

[[Common Accident Provision: ( ) Yes ( X ) No]]

[[Common Accident means if more than one Covered Person in the same immediate family incurs Covered Expenses as a result of the same accident, the Specific Deductible will be applied only once to all Covered Expenses Paid because of that accident for all Covered Persons in the family during the same Benefit Period.]]

[Description	Rates
Employee	\$ _____
Family	\$ _____
	\$ _____
	\$ _____

{[Specific Accommodation Reimbursement Endorsement

☐ Yes ☐ No \_\_\_\_\_

Specific Terminal Liability Endorsement

☐ Yes ☐ No \_\_\_\_\_

Aggregating Specific Deductible Endorsement

☐ Yes ☐ No \$ \_\_\_\_\_

Specific Step-Down Deductible Endorsement

☐ Yes ☐ No \_\_\_\_\_

Independent Review Organization Extended Liability Endorsement ☐ Yes ☐ No \_\_\_\_\_ ]}



**AGGREGATE EXCESS LOSS INSURANCE** ( X ) Yes ( ) No

Benefit Period: [Covered Expenses Incurred from 10/01/00 through 12/31/01,  
and Paid from 01/01/01 through 12/31/01.

Covered Expenses Incurred from 10/1/2000 through 12/31/2000 will be limited to 15% of the Annual Aggregate Deductible.]

Aggregate Excess Loss Insurance includes:

( X ) Medical ( X ) Stand Alone Prescription Drug Program ( ) Dental Care  
( ) Vision Care ( ) Weekly (Disability) Income [( ) Other \_\_\_\_\_]

Aggregate Percentage Reimbursable [100 %]

Maximum Aggregate Benefit: [\$1,000,000]

Minimum Annual Aggregate Deductible <sub>2</sub> [\$ N/A or 100 % of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: [\$ \_\_\_\_\_]

Monthly Aggregate Factors[						
Description	Medical	Prescription Drugs	Dental	Vision	Weekly Income	Other
Employee	\$					
	\$					
						]

Aggregate Excess Loss Premium [( X )\$ per [Employee] per month ( )annual \$ 400 ].

{Aggregate Terminal Liability Endorsement Premium: [\$ .65 per Employee per month]}

{Aggregate Terminal Liability Endorsement Monthly Factors: [xxxx]}

{Aggregate Accommodation Endorsement Premium: [\$ \_\_\_\_\_]}

{Independent Review Organization Extended Liability Endorsement ☐ Yes ☐ No \_\_\_\_\_ }

**SPECIAL CONDITIONS:**

[ \_\_\_\_\_ ]

# UNIMERICA INSURANCE COMPANY

A Stock Company

Administrative Offices: [6300 Olson Memorial Highway, Golden Valley, MN 55427]

Phone: 1-800-454-0233]

## APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

**Full Legal Name of Applicant:** [ABC Company]

**Address:** (street, city, state, and zip): [1234 Any Street, Any City, USA]

**Key Contact:** [John Doe]

**Telephone:** [123-456-6789]

**Tax ID:** [123456]

**Applicant is a:** ☐ Corporation ☐ Labor Union ☐ Partnership ☐ Association ☐ Proprietorship ☐ Other:

**Nature of Business of the Group to be Insured:** [Banking] **Requested Effective Date:** [1/1/2002]

**Total number of eligible persons:** [Employees: 150 Retirees: 0]

**Are retirees covered:** ☐ Yes ☐ No.

**Affiliates or Subsidiaries:**

**Addresses of Affiliates or Subsidiaries:**

[Full Name of Administrator: ABC Third Party]

[Address: \_\_\_\_\_ (street, city, state, and zip): \_\_\_\_\_]

[Key Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_]

[Agent or Broker: Jane Does]

[Tax ID: 123-66-6789]

[Address: 1234 Any Street, Any City, USA]

**{SPECIFIC EXCESS LOSS INSURANCE:** ☐ YES ☐ NO

**Benefit Period:** [Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ and  
Paid from \_\_\_\_\_ through \_\_\_\_\_. ]

[If this Policy has a Subsequent Policy Period, the Benefit Period is changed to:

Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ and Paid from \_\_\_\_\_ through \_\_\_\_\_. or, through any termination within the  
next Benefit Period, whichever is earlier.]

[Covered Expenses Incurred from \_\_\_\_\_ through \_\_\_\_\_ will be limited to \_\_\_\_\_ per Covered Person.]

**Specific Deductible** per [☐ Covered Person {☐ family}: \$ \_\_\_\_\_]

**Specific Percentage Reimbursable:** [ \_\_\_\_\_ ]

**Maximum Specific Benefit** per [☐ Covered Person {☐ family}: \$☐ Unlimited ☐ Other \$ \_\_\_\_\_]

**Covered Expenses Under Specific Excess Loss:** [☐ Medical ☐ Stand Alone Prescription Drug Program]

**{[Common Accident Provision:** ☐ Yes ☐ No]}

Description:	Rates: {the rates below will increase by <sub>3</sub> [5%]- if the Access To <sub>4</sub> [OptumHealth Care Solutions] Agreement is not signed}
[Employee	\$
	\$
	\$
	\$ _____ ]

{Minimum Specific Premium \$ \_\_\_\_\_}

- {[1. Specific Accommodation Reimbursement Endorsement ☐ Yes ☐ No  
2. Specific Step-Down Deductible Endorsement ☐ Yes ☐ No  
3. Specific Terminal Liability Endorsement ☐ Yes ☐ No  
4. Aggregating Specific Deductible Endorsement ☐ Yes ☐ No  
5. Independent Review Organization Extended Liability Endorsement ☐ Yes ☐ No ]}}

UMERAPP-AR (01/12)

☐ NO

Covered Expenses Incurred from 10/1/2001 through 12/31/2001 will be limited to 15% of the Annual Aggregate Deductible.]

☒ Medical    ☐ Dental    ☐ Vision  
☒ Stand Alone Prescription Drug Program  
☐ Other (Please Specify)                      ]

**Maximum Aggregate Benefit:** ☐ \$500,000 ☒ \$1,000,000 ☐ Other \$ \_\_\_\_\_

**Minimum Annual Aggregate Deductible:**  $\frac{1}{12}$  [\$123,000 or 100% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.]

**[Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: [\$**

**Aggregate Excess Loss Premium:** \$10.00 per employee per month]

**{Aggregate Terminal Liability Endorsement:**    ☒ **Yes**    ☐ **No**    [☒ **Monthly**    ☐ **Annually**    \$.65 per employee]

**{Aggregate Accommodation Endorsement:** ☒ Yes ☐ No ☒ Monthly ☐ Annually \$1.00 per employee}}

**{Independent Review Organization Extended Liability Endorsement** ☐ Yes ☐ No [ ]

Monthly Aggregator Factors:[					
Covered Persons	Medical	Prescription Drugs	Dental	Vision	
Employee					
					1

**It is understood and agreed by the undersigned that:**

- a. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
- b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document [within 90 days] after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document [within 90 days], the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
- c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
- d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
- e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.
- f. {The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned. }

- g. [Other: {The undersigned Employer understands the rates for Specific Excess Loss Benefits includes the use [OptumHealth Care Solutions Network] and has signed the Access To Transplant Services Agreement. If the Access To Transplant Services Agreement is not signed and attached to this application, the rates for Specific Excess Loss Benefits will be increased by [5%-15%].}]
- h. NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

**The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.**

Full Legal Name of Applicant: \_\_\_\_\_

Signature of Authorized Person: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Agent or Broker: \_\_\_\_\_

Print Name of Agent or Broker: \_\_\_\_\_

**FRAUD WARNING NOTICES:**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.**



SERFF Tracking Number: UHLC-127756046

State: Arkansas

Filing Company: Unimerica Insurance Company

State Tracking Number: 50098

Company Tracking Number: IROEXT (01/12)

TOI: H12 Health - Excess/Stop Loss

Sub-TOI: H12.004 Self-Funded Health Plan

Product Name: Stop Loss

Project Name/Number: IRO Amendment/

## Supporting Document Schedules

	Item Status:	Status
<b>Bypassed - Item:</b> Application	Approved-Closed	<b>Date:</b> 10/31/2011
<b>Bypass Reason:</b> See Form Schedule		
<b>Comments:</b>		

	Item Status:	Status
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	<b>Date:</b> 10/31/2011
<b>Comments:</b>		
<b>Attachment:</b>		
Readability Certification.pdf		

	Item Status:	Status
<b>Satisfied - Item:</b> Explanation of Variables	Approved-Closed	<b>Date:</b> 10/31/2011
<b>Comments:</b>		
<b>Attachments:</b>		
Variability for schedule and app 2011-ar.pdf		
Variables under UIC IRO Endorsement filing.pdf		

**CERTIFICATION OF COMPLIANCE  
FOR  
READABILITY**

<b><u>Form Number(s)</u></b>	<b><u>Flesch Readability Score</u></b>
<b>IROEXT (01/12)</b>	<b>41</b>
<b>UMEREL (01/12) SCHED</b>	<b>NA</b>
<b>UMERAPP-AR (01/12)</b>	<b>NA</b>

I hereby certify on behalf of **Unimerica Insurance Company** that the above Flesch Scale Analysis Readability Score is accurate, based on the computer program used to calculate the scores, and comply with the readability requirements in your state.

Signature



Print Name

Jayne Jackowski

Title

Compliance Analyst

Date

October 25, 2011

## VARIABLE ITEMS UNDER THE UNIMERICA EXCESS LOSS INSURANCE SCHEDULE AND APPLICATION

1. Straight brackets indicate variable in their specifics without change in the subject. Examples of such would be Policyholder name, effective date, group number and eligibility wording.
2. Wavy brackets indicate variable by omission.
3. Specific Deductible per Covered person will be <sub>1</sub>[\$20,000] or more;
4. Annual Aggregate Deductible for groups of fifty (50) or fewer is the greater of:
  - (A) Four thousand dollars (\$4,000) multiplied by the number of group members;
  - (B) One hundred and twenty percent (120%) of expected claims; or
  - (C) Twenty thousand dollars (\$20,000);
5. Annual Aggregate Deductible for groups of fifty-one (51) or more is one hundred ten percent (110%) of expected claims or greater; or
6. Application Only: Specific Rates: <sub>3</sub>[5-15%]
7. Application Only: Specific Rates: <sub>4</sub>[OptumHealth Care Solutions Network] could be replaced with another facility or add another facility to the [OptumHealth Care Solutions Network].

VARIABLE ITEMS UNDER  
THE UNIMERICA INSURANCE COMPANY  
EXTENDED LIABILITY ENDORSEMENT  
TO THE EXCESS LOSS INSURANCE POLICY

Straight brackets indicate variable text.

<b>Variable</b>	<b>Description</b>
Heading	Variable to change as optional reason for extended liability.
	Client specific policyholder name and effective date will be inserted in the appropriate variable sections.
Superscript 1	Only the coverage affected will be included.
Superscript 2	Language may reflect another reason to extend the paid period other than reversal by an IRO.
Superscript 3	Period may be from 3 months – 24 months.
Superscript 4	Language may reflect another reason to extend the paid period other than reversal by an IRO.
Superscript 5	Variable by omission
Superscript 6	Language may reflect another reason to extend the paid period other than reversal by an IRO.
Superscript 7	The period of time coverage must be in force is variable.